

Response to Request for Input: Data & Evaluation Subcommittee

Behavioral Health Integration Stakeholder Input

Submitted by The Institute for Innovation & Implementation,

University of Maryland School of Social Work

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Data can and should be used to support the selection of the most appropriate model for behavioral health integration in Maryland and to track access, quality, and cost of care after implementation of the new design. These types of data may be very different and should be considered apart from one another.

SELECTING A MODEL FOR BEHAVIORAL HEALTH INTEGRATION

It is important to note that in terms of coordination between physical and behavioral health care, effective integration or coordination occurs at the practice (provider) level, regardless of the managed care design (Pires, 2011). Therefore, there are pros and cons of each of the proposed models as it relates to behavioral health services **for children and their families** (i.e., from the perspective of the children's behavioral health system). However, it becomes clear that there are certain system designs that can better support youth with serious and complex behavioral health needs and their families. A **behavioral health organization (BHO; Model 2)** would better support the particular needs presented by children and allow the flexibility of services and coordination required across child- and family-serving systems (e.g., child welfare, education, juvenile justice, etc.). Efforts in Maryland both to implement the Patient Protection and Affordable Care Act (aka Health Care Reform) and integrate behavioral health services have recognized the unique needs of children with intensive, multi-system requirements. Nationally, experts agree on the need to *coordinate* physical and behavioral health care for children. However, the integration of financing and management for physical and behavioral health care for all populations, without specialty service delivery design for behavioral health care for children, has led to child behavioral health funding being absorbed by physical health expenditures, primarily for the care of adults.

Children with serious behavioral health disorders do not have the same high co-morbid chronic medical conditions as the adult population. Instead, these populations of children have more intensive needs for coordination with social services, the courts and education. Integrated primary and behavioral health care models designed for adult populations often fail to adequately incorporate the complex multi-system service and fiscal coordination required to effectively and efficiently serve children with complex behavioral health needs and their families (Pires, S., personal communication).

Children in Medicaid who use behavioral health services have higher mean Medicaid expenditures (physical health and behavioral health care) than Medicaid children in general. **Expenditures are driven more by behavioral health service use than by physical health service use** except for children categorized as SSI/Disabled for whom mean physical health expenditures are slightly higher (Pires, Allen, Grimes, Mahadevan, & Gilmer, 2012; see table below). Children with mental health and substance abuse disorders represent less than 10% of the overall Medicaid child population but this 10% represents an estimated 38% of the total Medicaid child expenditures (Pires et al, 2012). As noted in a report issued by the Maryland Coalition of Families for Children's Mental Health, families of children with serious behavioral health needs indicated that **"the mental health and behavioral needs of the children far overshadowed the physical health needs.** To each question about medical or dental care, all of the families responded that their child's mental health was the major factor in every aspect of their child's life and often consumed the majority of the caregiver's time, energy and resources"(Geddes & Walker, 2012, p.6).

Children with serious behavioral health problems are often involved with multiple systems: child welfare, juvenile justice, education, and the courts. As mentioned earlier, integrated primary and behavioral health care models designed for adult populations often fail to adequately incorporate the complex multi-system service and fiscal coordination required to effectively and efficiently serve children with complex behavioral health needs and their families.

	All Children Using Behavioral Health Care	TANF	Foster Care	SSI/Disabled**	Top 10% Most Expensive Children Using Behavioral Health Care***
Physical Health Services	\$3,652	\$2,053	\$4,036	\$7,895	\$20,121
Behavioral Health Services	\$4,868	\$3,028	\$8,094	\$7,264	\$28,669
Total Health Services	\$8,520	\$5,081	\$12,130	\$15,123	\$48,790
<p>* Includes children using behavioral health services who are not enrolled in a comprehensive HMO, n = 1,213,201</p> <p>** Includes all children determined to be disabled by SSI or state criteria (all disabilities, including mental health disabilities)</p> <p>***Represents the top 10% of child behavioral health users with the highest mean expenditures, n = 121,323</p> <p>Source: Pires, S., Allen, K., Grimes, K., Mahadevan, R., Gilmer, T. (2012). Faces Study on Child Behavioral Health Service Use and Expense. NJ: Center for Health Care Strategies.</p>					

USING DATA TO MANAGE THE REDESIGNED BEHAVIORAL HEALTH SYSTEM

As a national leader in mental health service delivery, Maryland should take this opportunity connect its data collection and measurement to the measures that are being developed by the Agency for Health Care Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) at the U.S. Department of Health and Human Services. Under the Children's Health Insurance Plan Reauthorization Act (CHIPRA) of 2009, an initial set of core measures was developed to measure children's health care quality (Mann, 2011). Those measures have been assessed through multiple layers of public comment and stakeholder involvement, and additional measures have been recommended and are under consideration. The CHIPRA legislation authorized not only the initial core set of children's measures but also the development of the Pediatric Quality Measures Program and the creation of a national technical assistance program. The Pediatric Quality Measures Program is working on testing and refining the initial core measures as well as establishing additional measures to address other aspects regarding quality of care (Mann, 2011).

By January 2013, States will be expected to begin collection of the CHIPRA Core Measures and report them to CMS by December 31, 2013. Although many of the initial core measures were not specific to behavioral health (which was noted by the reviewers and was a focus of the request for public comment during the Spring of 2012), there were several that are relevant to the population of children and youth that are served by the public behavioral health system. There will be multiple additional iterations of the core set through at least 2015 that will be based on input from the various Centers of Excellence and from CHIPRA Quality Demonstration Grantees. Additionally, States will be required to implement the Consumer Assessment of Healthcare Providers and

Systems (CAPHS) Survey along with voluntary core quality performance measures (Mann, 2011). The CAPHS includes specific assessments with regard to the care received by children and their caregivers and assesses, among other variables, issues of access to care and family engagement in care (see <https://cahps.ahrq.gov> for copies of the survey tools).

Therefore, in addition to incorporating the measures and tools identified and tested by HHS and its partners, the State should consider measuring outcomes in terms of both immediate health and functional outcomes *as well as* longer term outcomes.

Immediate outcomes might include:

- decreased utilization of psychiatric emergency department, psychiatric inpatient hospitalizations, and residential treatment centers;
- increased days in attendance at school, in job-training, or at work; and,
- improvement based on clinical and functional assessment tools.

Longer-term outcomes, however, should focus not only on the children's physical and behavioral health but also on their ability to:

- live in their home and community,
- successfully complete school,
- remain out of the juvenile justice system, and,
- have their caregivers be healthy and productive members of the community.

We know that children's disabilities have been shown to have considerable impact on the health, well-being and workforce participation of their parents; therefore, the measurement of the effects of interventions should include parent outcomes in addition to child-level outcomes (Perrin, 2012). A recent Institute of Medicine report called for a "life-course approach to the measurement of health and health care quality, with new emphasis on the social and behavioral determinants of health and monitoring disparities in health and health care" (2011, p.4).

It is critical that the new behavioral health system in Maryland align itself with federal measurement initiatives and position itself as a leader in comprehensively assessing outcomes for the entire family in both the short- and long-term. The combination of quality service delivery and forward-looking data collection and evaluation activities will ensure continued excellent service coordination for youth and families in Maryland.

Works Cited

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